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Scoliosis

SCOLIOSIS is the most deforming orthopedic problem confronting children. It is a potentially progressive condition affecting children during their active growth and significantly subsiding upon completion of spinal growth. Early recognition is mandatory so that treatment to prevent structural scoliosis can be carried out.

There are numerous causes of scoliosis but the idiopathic type is most prevalent (60 percent). Recent studies have indicated a familial preponderance and idiopathic scoliosis is now considered familial. Girls outnumber boys nine to one but no endocrine basis is known.

Early treatment, the application of a Milwaukee brace or its equivalent, has been effective. This is dynamic correction which incorporates an exercise program within the brace.

Surgical intervention employs internal instrumentation, the Harrington rod, which corrects most curves by 50 percent. Fusion after application of the rod requires cast immobilization for six to nine months.

Internal correction by the Dwyer method has gained credence. This requires sequential disectomy and instrumentation to correct the curve. Halo-pelvic or halo-femoral traction permits beneficial correction of curve preoperatively.

The numerous new surgical techniques are drastic surgical procedures that could be decreased or eliminated if early curves were detected by large scale pediatric screening.

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Sex and Patients With Spinal Cord Injuries

SEXUAL FUNCTION, once thought to be lost after spinal cord injury, is now known to continue for most men and women. Parents of children born with meningomyelocele and spinal cord defects now can anticipate that their children's rehabilitation can include sex information which puts the spinal cord injured adolescent into an active role. Extensive experience from many centers over recent years confirms this. Yet, how can these things be true for those persons who have sensorimotor losses preventing transmission of genital sensation to the brain, experiences of physical orgasm, external ejaculation, psychogenic penile erections or vaginal lubrications, or who have indwelling catheters or bowel incontinence?

At the University of Minnesota, we have learned that several changes in the physician's approach to a patient with a spinal cord injury have made a major difference. First, we have learned to view sex as only a part of sexuality and sexuality as an important health issue, deserving active and sensitive attention. Sexual adjustment after spinal cord injury is now a part of the treatment plan just as much as bladder function or spinal stability training or education in the activities of daily living.

Second, we have learned that sexuality is not equated with genitality or procreation. Genital pleasuring is only one form of sexual expression and sex for recreation is more common than sex for procreation.

Third, great human energies can be locked up or freed by sexuality. These energies are capable of propelling a person with a damaged spinal cord forward into a job and a productive life or oppressing his sense of self-esteem and adding a new disability onto the motor and sensory paralysis.

Fourth, mobility and communication usually are linked together in the able-bodied state. After injury to the spinal cord, persons learn that effective communication can compensate greatly for loss of mobility. And sexuality is a potent communication tool to be used wisely and with respect.

Last, as Weiss and Diamond have shown, realistic acceptance of physical disability often is best seen in those who have a realistic acceptance of their sexuality. For physicians, sexuality no longer need be considered a difficult subject to include in the rehabilitation process; it is in fact a facilitating one.

Which direction a person with spinal cord